attn: LISA.

Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Thomas Mehlhoff 6410 Fannin, Suite 1100 Houston, TX 77030	MFDR Tracking #: M4-07-0551-01 DWC Injured Date Emplo Insurance
Respondent Name and Box #: University of Texas System Rep. Box #: 46	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUME

Requestor's Position Summary: "Not paid according to the 2005 fee"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $65.01
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

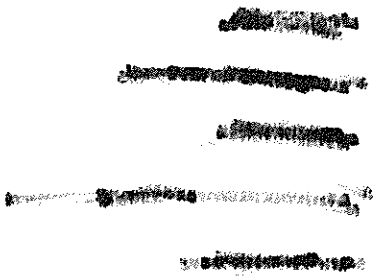
Respondent's Position Summary: None Provided

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
10/06/05	99203-25	W1	1, 3, 5, 6	$57.02
10/06/05	29105	W1, B13, W4	2, 4, 5, 6	$7.99
Total Due:				$65.01

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.



1. These services were partially reimbursed by the Respondent with reason code "W1 – Worker's comp state fee schedule adjustment."
2. These services were partially reimbursed by the Respondent with reason code "W1 – Worker's comp state fee schedule adjustment" and "B13 – Previously paid. Payment for this claim/service provided in a previous payment" and "W4 – No additional reimbursement allowed after review of appeal/reconsideration."
3. CPT code 99203 has a MAR of $99.42 x 125% = $124.28. Respondent has made reimbursement previously of $67.25. Additional reimbursement is due to Requestor in the amount of $57.02 as requested on Table of Disputed Services per Rule 134.202(d).
4. CPT code 29105 has a MAR of $86.59 x 125% = $108.24. Respondent has made reimbursement previously of $100.24. Additional reimbursement is due to Requestor in the amount of $7.99 as requested on Table of Disputed Services per Rule 134.202(d).
5. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."
6. Per review of Box 32 on CMS-1500, zip code 77030 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

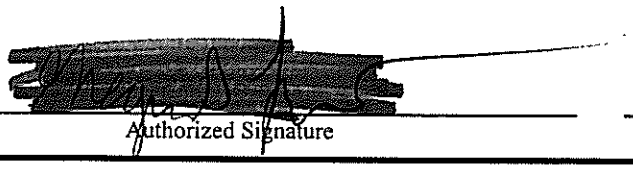
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $65.01 plus applicable accrued interest per Division Rule 134.803 due within 30 days of receipt of this Order.

ORDER:



Authorized Signature | Medical Fee Dispute Resolution Officer | 11/21/07 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.